Medicaid Information Bulletin

July 1999

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99 - 54 Medicaid Budget Hearing for Fiscal Year 2001

The Department of Health invites you to attend a special Medical Care Advisory Committee (MCAC) meeting to obtain public input on the Medicaid and UMAP (Utah Medical Assistance Program) budgets for Fiscal Year 2001. The meeting will be held

Thursday, July 15, 1999
4:00 p.m. until 6:00 p.m
at
the State Office Building Auditorium
(north of the State Capitol Building)

Fiscal Year 2001 is July 1, 2000 through June 30, 2001. The MCAC is an advisory group which recommends funding and program directions to the Department of Health and the Governor.

If you know of special medical needs not being met by the Medicaid or UMAP programs, or want to speak on a budgetary matter of importance to you, please come prepared to make a short (no more than five minutes) presentation to the Committee. Copy services will be provided if you have a handout. SIGNED PETITIONS ARE ENCOURAGED. Your input will assist the MCAC in recommending a budget that will be more representative of Medicaid and UMAP providers and clients.

If you cannot attend the public hearing, but would like to write to the Committee of special medical needs, please mail comments by Tuesday, July 6, 1999, to:

MCAC
Box 143105
Salt Lake City, UT 84114-3105

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99 - 55 Medicaid Bulletins Now in Acrobat Reader

The software product Adobe Acrobat Reader® allows the Medicaid Information Bulletin to appear on the Internet exactly as the original, printed document. Text, columns, graphics, fonts and formatting are preserved. You can print copies which look just like the original bulletin using any computer, any browser, and any printer. Acrobat Reader is a FREE product.

If Acrobat Reader is installed on your personal computer, you just 'click' on the link to the bulletin to view it.

Installing Adobe Acrobat Reader

If Acrobat Reader is not yet installed, and you have a new version of an Internet browser (for example, Netscape 4. or newer), usually Acrobat Reader will self-install on your computer when you click' on the link to the bulletin. After a short delay for the one-time only installation, the bulletin will open in a separate window.

If your Internet browser is an older version, you may have to assist the software installation. 'Click' on the link to Adobe Acrobat Reader and follow instructions. With some browsers, you may have one more step. If presented with a menu choice before the bulletin opens, choose 'pick app'. Select the file 'acrord 32.exe', typically located in the folder Netscape - Acrobat 3 - reader - program. Select the 'acrord 32.exe' file to complete installation of Acrobat Reader. Once Reader is installed, the bulletin will open in a separate window.

If you have problems, Adobe offers customer support. Check out their trouble shooting suggestions on the Internet from the link:

http://www.adobe.com/supportservice/custsupport

Provider Manuals to Be Published in Adobe Acrobat

Eventually, all Utah Medicaid Provider Manuals will be published on the Internet in Adobe Acrobat. Should the user want to print the manual, it will appear exactly as intended. If there are questions about the use of Adobe Acrobat or comments about the format of bulletins and provider manuals, please contact the editor Donna Kramer.

E-mail: dkramer@doh.state.ut.us

Office Telephone: 801-538-7077

Toll-free: 1-800-662-9651 (Medicaid Information); ask to be transferred to Donna Kramer. ☐

99 - 56 Child Health Evaluation and Care Screening Payment Rates Increased

Based on review of the CHEC screening fee for service payment rates, the Division of Health Care Financing increased payment rates for CHEC well-child visits effective 01 March, 1999. These new rates reflect payment from Medicaid for services billed to Medicaid. Rates for these services may be different through your HMO contracts. The new fee for service rates are listed below:

CPT Code	Description	Old Fee	New Fee
New Patient			
99381	Infant <1 Yr	$37.45	$58.65
99382	early childhood (1 through 4)	$37.45	$58.65
99383	late childhood (5 through 11)	$37.45	$67.10
99384	adolescent (12 through 17)	$37.45	$75.54
99385	adolescent (17 through 21)	$37.45	$70.85
Established Patient			
99391	Infant <1 Yr	$37.45	$50.44
99392	early childhood (1 through 4)	$37.45	$58.65
99393	late childhood (5 through 11)	$37.45	$58.65
99394	adolescent (12 through 17)	$37.45	$67.10
99395	adolescent (17 through 21)	$37.45	$63.10

Rates for New Born Care (CPT 99431, 99432 and 99435) were increased in 1996.

The CHEC screening fee includes payment for all components of the CHEC Screening. Additional services, such as administration of immunizations, laboratory test and other diagnostic and treatment services, may be billed in addition to the CHEC screening. Reimbursement for these services for a child enrolled in an HMO is based on the provider's agreement with the HMO.

In addition, code 44361 EGD/Biopsy has been increased to $180.88. We have received a number of questions on CPT code 93321--Cardiac Doppler. The rate in the fee schedule is correct, but this code shows up in two areas of the Medicaid payment system. If not properly coded, the provider will receive only $8.44, rather than $35.42. Care should be used in coding this procedure to reflect the service performed.

As always, we encourage you to perform CHEC well-child exams and educate Medicaid families about the importance of this preventive service. Information and protocol for the CHEC well-child exam can be found in the Utah Medicaid Provider Manual for CHEC Services. □

99 - 57 Attendance at Delivery and Neonatal Resuscitation

Effective June 1, 1999, CPT code 99436, Attendance at Delivery, became available for use by board certified neonatologists and board certified pediatricians in urban or rural areas. Family practice physicians **trained** in neonatal care who practice in rural areas will be recognized and included for reimbursement.***** This code can be used when a high risk delivery is expected, Neonatal Risk Factor Classification Levels three or four are met, and stabilization of the newborn is anticipated. The delivering physician must request the attendance of a qualified neonatologist, pediatrician or family practitioner at the high risk delivery. When resuscitation is required, CPT code 99440 would be used in place of 99436. The two codes cannot be used together.

***** The American Academy of Pediatrics recognizes primary care pediatrician and neonatologist expertise in neonatal resuscitation and intubation. The American Academy of Family Practice Physicians and the American College of Obstetricians and Gynecologists have a joint policy statement which requires physicians attending delivery to maintain neonatal resuscitation skills. Board certified neonatologists, board certified pediatricians, and family practice physicians practicing in rural areas are responsible for maintaining neonatal resuscitation skills.

Criteria for Neonatal Care

Code 99436, Attendance at delivery, is on the Medical and Surgical Procedures Code List which is included with the Utah Medicaid Provider Manual for Physician Services. The note for code 99436 is changed from non-covered to covered with a limitation. The changes are in bold print in the note which follows:

99436 Attendance at delivery (requested by attending physician) and initial stabilization of newborn
PRIOR APPROVAL: Not Required
CRITERIA: Approved for neonatologists, pediatricians, and rural family practitioners only. Refer to Criteria #30.

A new Criteria #30 (Neonatal Care) is added to the Medical and Surgical Procedures Code List.

Physician Services Manual Updated

In addition to the changes made to the Medical and Surgical Procedures Code List, the Utah Medicaid Provider Manual for Physician Services, Section 2, Physician Services, Chapter 3, LIMITATIONS, is revised to add a new item HH, Neonatal Care Delivery. Because there are other pages revised in the Physician Services Manual, the instructions for updating Section 2 and the Medical and Surgical Procedures Code List are in Bulletin 99 - 72, *Physician Services Manual Updates*. □

99 - 58 Laboratory Tests for Dialysis Patients

Policy on laboratory tests to monitor the progress of dialysis patients is added to three Medicaid Provider Manuals:

- Physician Services, Section 4, Laboratory Services;
- Laboratory and X-ray Services, Section 2; and
- Hospital Services, Section 4, End Stage Renal Disease.

The new policy concerns lists of tests and frequencies which constitute the level and types of routine laboratory tests that are covered under the Composite Payment Rate. Other tests are considered non-routine and can be billed separately. Routine tests at greater frequencies must include medical justification. The schedule is based upon recommendations from the Health Care Financing Administration for Medicare patients eligible for End Stage Renal Disease (ESRD) services.

Hepatitis B Surface Antigen (HbsAg) and Anti-HBs for hepatitis B are covered when patients first enter a dialysis facility. Coverage of future testing in these patients depends on their serologic status and on whether they have been successfully immunized against hepatitis B virus. A table is added to summarize the frequency of serologic surveillance for hepatitis B. Tests furnished according to this table do not require additional documentation and are paid separately because payment for maintenance dialysis treatments does not take them into account.

Updating Provider Manuals

Physicians, labs and hospitals will find attached revised pages to update their respective provider manuals. A vertical line is placed in the margin next to text which has changed. Instructions for updating manuals follow.

- **Physician Manual, Section 4, Laboratory Services**

  The policy on laboratory tests is added to the Utah Medicaid Provider Manual for Physician Services, Section 4, Laboratory Services, Chapter 2, COVERED SERVICES, as a new item A. Because there are other pages revised in the Physician Manual, the instructions for updating Section 4 are in Bulletin 99 - 72, *Physician Services Manual Updates*.

- **Laboratory and X-ray Manual: Section 2**

  - Remove original page 1 and replace with page 1 dated July 1999. Page numbering is changed to accommodate pages added.

  - Remove existing pages 6 - 7 in Section 2 and replace with the attached pages 6 through 13. An index is added to the last page.

- **Hospital Manual, Section 4, End Stage Renal Disease**

  - In Section 4, End Stage Renal Disease, remove original page 1 and replace with page 1 dated July 1999. Page numbering is changed to accommodate pages added.

  - Also in Section 4, remove existing pages 6 - 7. Replace with the attached pages 6 through 9.

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99 - 59 Telehealth for Special Health Care Needs Children Project

The Utah Medicaid Program is pleased to announce a joint venture between Medicaid and the Special Health Care Needs Child demonstration project to explore telehealth as an option to provide care to Medicaid clients. Telehealth, or telemedicine, services are an additional method of delivering health care to patients in under-served rural areas. Medicaid views telehealth no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective thorough medical assessment, or problems in patient understanding or acceptance of telehealth, hands-on-assessment and/or care must be provided for the patient. Quality of health care must be maintained regardless of the mode of delivery.

Definitions

Telehealth or Telemedicine is a technological method of providing an auditory and visual connection between the consultant at a remote site and the patient who is assisted by a Health Department clinician at the rural Health Department clinic.

Authorized providers: The University of Utah telehealth site will provide access for physician and dietitian consultation. Health care providers are limited to physicians and dietitians during the beginning of the Children's Special Health Care Needs pilot project. Other speciality areas may be added later as the project continues. For Medicaid reimbursement, University of Utah telehealth connections to rural areas must be located within Utah, and health providers must be licensed in Utah.

Covered Services

Medically necessary diagnostic and therapeutic services, appropriate for the adequate diagnosis or treatment of some Special Health Care Needs Children, are covered services. The services include initial physician consultation, confirmatory consultations, and follow up consults. The service and codes will be limited to those which might be appropriate for evaluation and consultation without hands-on-care.

Limitations

- For Medicaid and the Special Health Care Needs Children project purposes, health care delivery through telehealth is only relevant for Special Health Care Need's Children residing in rural areas. It provides the child with access to a health provider specialist in an urban area without travel from the rural area. Health Department clinics in Milford, Price, and Richfield with telehealth connections to the University of Utah telehealth site are eligible for inclusion in the project.

- Providers are limited to physicians and dietitians working through the University of Utah telehealth site as participants in the Special Health Care Needs Child project. Each health provider must have a Medicaid provider number.

- Providers will ensure that the legal guardian of the Special Health Care Needs Child signs a consent to authorize the child's participation in the telehealth project. Without signed consent, the child is not eligible to participate in telehealth.

Billing/Payment

Bill on a HCFA 1500 Claim form. All payments will be made to the Bureau of Children with Special Health Care Needs in the Division of Community and Family Health Services, Department of Health. No payments will be made for telehealth transmission expense or facility charge.

Codes

Codes which may be used by telemedicine physician consultants:

- 99201 - 99205, initial outpatient consultation
- 99211 - 99215, outpatient established patient

Codes which may be used for dietician consultation:

- Y8880, dietician consultation

  This is a new code which specifically describes dietician education and consultation for Special Health Care Needs Child during the telehealth project. Dietician consultation for the family will average four per year.

Telehealth Modifiers

Each dietician and physician provider consultant must add the appropriate modifier listed below to indicate the service was provided through telehealth. The modifier is required to monitor and evaluate the financial impact of this project.

GT Teleconsultation (face to face real time) consulting provider

The UHIN standard for Telehealth includes two other modifiers. However, the only service Medicaid will cover at this time is identified by the GT modifier. The non-covered modifiers are TR, Presenting/Referring provider (face to face real time), and TD, Teledata, teleradiology.

Physician Services Manual Updated

The policy on telemedicine is added to the Utah Medicaid Provider Manual for Physician Services, Section 2, Physician Services, Chapter 2, COVERED SERVICE, as a new item 29. Because there are other pages revised in the Physician Services Manual, the instructions for updating Section 2 are in Bulletin 99 - 72, *Physician Services Manual Updates*. □

99 - 60 ICD-9 Code Required on Pediatric Prescriptions for Amphetamines

Effective August 1, 1999, prescribers must hand write a correct ICD-9 code on all Medicaid prescriptions for amphetamines, such as Adderall®, Dexedrine®, and Desoxyn®, for children age 18 and younger. Acceptable ICD-9 codes are for the hyperkinetic syndrome of pediatrics. On August 1, this requirement will replace the current requirement to obtain telephone prior approval for coverage of amphetamines for pediatric ADD or pediatric ADHD.

ICD-9 Documentation Required

Prescribers must hand write the code on the prescription. Telephoning the code to a pharmacy after the fact is not acceptable. In order for the claim to be paid by Medicaid, the prescriber must write a correct code within the range of codes for hyperkinesis, and the pharmacist must enter that code into the ICD-9 field. The claim will be denied if an incorrect code is entered into the ICD-9 field.

NOTE: The ICD-9 code requirement pertains only to products classified as amphetamines. Methylphenidate (Ritalin®) is in a different therapeutic class and is not included in the requirement for pediatric, amphetamine prescriptions.

The policy that authorizes the use of the ICD-9 code is approved by the Medicaid DUR Board and the Utah Medical Association. Pharmacies and pharmacy software vendors were informed of the intent to use the ICD-9 field over a year ago.

Amphetamine Prescriptions for Adult ADD or ADHD

Amphetamine prescriptions for adult ADD or ADHD will continue to require written prior approval. There is a correction on the Drug Criteria and Limits List in the criteria for amphetamines for adults. In the COMMENTS column, the last sentence of Item 1 with examples of single chemical amphetamines is changed to read: "This includes Redux or Phen/Fen."

Drug Criteria & Limits List Updated

Prescribers and pharmacists will find attached pages 7 - 8 of the Drug Criteria & Limits List corrected to include the changes described in this bulletin. A vertical line is placed in the margin next to text which has changed.

Provider Manual for Physician Services

Because there are other pages corrected in the Utah Medicaid Provider Manual for Physician Services, the instructions for replacing pages 7 - 8 are in Bulletin 99 - 72, *Physician Services Manual Updates*.

Provider Manual for Pharmacy Services

Pharmacists will find attached a revised Table of Contents and pages 7 - 8 for the Drug Criteria and Limits list. See also Bulletin 99 - 62, *Drugs Moved from the Drug Criteria & Limits List to the Injectable Medications List*.

□

99 - 61 Prescribers and Pharmacists: Over-the-Counter Drug List Updated

The Over-the-Counter (OTC) Drug List is updated effective July 1, 1999. A new list is attached for pharmacists, physicians and other prescribers. A vertical line is placed in the margin next to text which has changed. An asterisk (*) marks where text was deleted. Changes are listed below. Other providers who want a copy should contact Medicaid Information; ask for the July 1999 Over-the-Counter (OTC) Drug List.

Coverage expanded

Medicaid covers the following OTC items:
- Citrate of magnesia 600 ml, maximum
- MAG-CARB, Brand Name allowed
- Motrin 15 ml drops: NDC 00045052415; Brand Name allowed
- Motrin 120 ml: NDC 00045019204; Brand Name allowed
- Motrin 120 ml: NDC 00045019240; Brand Name allowed

Coverage Limited

- Lancets are limited to 100/month maximum.

Other Changes to OTC List

- Acetone tests: Acetest. (Chemstrip-k, Ketostix, etc. is deleted.)
- Antacid liquid and tablets: Tums rolls, covered; Tums -500, E-X, and Ultra NOT covered
- AXID AR: Brand Name allowed
- DDS caps, liquid, and syrup and concentrate drops 5%: (Na+ or Ca++ salt)
- Glucose blood tests deleted.
- Glucose urine tests renamed as simply "Urine tests." No change in conditions of coverage.
- Insulin: Brand Name allowed
- Pepcid AC: Brand Name allowed
- Pepto-Bismol and generic equivalent
- Prophylactics, male, female: Brand Name allowed
- Tagamet HB and generic equivalent: package size is $\geq$ 30; Brand Name allowed

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99 - 62 Prescribers and Pharmacists: Drugs Moved from the Drug Criteria & Limits List to the Injectable Medications List

The Drug Criteria and Limits List will now be limited to drugs billed by pharmacists with an NDC code. It will no longer include products billed by the prescriber. Criteria for products billed by the prescriber, such as injectable medications, are now included on the Injectable Medications List in the Utah Medicaid Provider Manual for Physician Services. Consequently, Synagis®, Respigam®, and RotaShield ® (rotavirus vaccine, live, oral, tetravalent) are removed from the Drug Criteria and Limits List. For more information about these products, refer to Bulletin 99 - 64, *Injectable Medications: Rotashield, Interferon Beta-1A, Herceptin, Synagis, Respigam.*

Updating the Drug Criteria & Limits List

To economize on printing and mailing costs, the pages on which products are removed from the Drug Criteria and Limits List will not be reissued now. Instead, on page 1 of the list, delete Synagis, Respigam, and RotaShield from the Table of Contents. On page 13, cross out the criteria for Synagis and Respigam. On page 15, cross out the criteria for RotaShield.

If you want the revised list with the three products billed by the prescriber removed, contact Medicaid Information. Ask for the July 1999 Drug Criteria & Limits List.

Injectable Medications List Updated

The Injectable Medications List is revised to add the products listed in bulletin 99 - 64, *Injectable Medications: Rotashield, Interferon Beta-1A, Herceptin, Synagis, Respigam*. Because there are other page corrections for the Physician Services Manual, the instructions for replacing pages in this list are in Bulletin 99 - 72, *Physician Services Manual Updates*.

Pharmacy Services Manual Updated

Pharmacists will find attached a revised page 1, Table of Contents for the Utah Medicaid Provider Manual for Pharmacy Services. The revision corrects the dates for two attachments to the Provider Manual: the OTC and Drug Criteria and Limits lists. ☐

99 - 63 Q Codes Not Covered

The Injectable Medications List is revised effective July 1, 1999, to remove drugs with a Q code. Medicaid does not cover injectable medications with a Q code. Specifically, code Q0136, Epoetin Alpha, is no longer covered. ☐

99 - 64 Injectable Medications: Rotashield, Interferon Beta-1A, Herceptin, Synagis, Respigam

Criteria for coverage of rotavirus vaccine is corrected. Also, the Injectable Medications List is revised to add the products listed in this bulletin, specific criteria for coverage and billing instructions.

RotaShield (rotavirus vaccine)

There are several corrections to the criteria for coverage of rotavirus vaccine which was published in April 1999 (Bulletin 99 - 43, *Coverage of RotaShield ® (rotavirus vaccine, live, oral, tetravalent).*

- RotaShield® is approved by the CDC for the VFC program. However, the CDC has not yet signed a contract with the vaccine's manufacturer, so it is not currently available through that program. Until it becomes available through the VFC program, Medicaid will cover RotaShield. Once RotaShield is available through the VFC program, Medicaid will discontinue coverage.
- The effective date is January 1, 1999.
- The age limit is reduced to nine months, effective July 1, 1999.
- Doses may begin at age three months and should be given one month apart, for a total of three doses. The oldest age to begin dosing is six months due to the age limit of nine months.

The correct criteria are on the Injectable Medications List attached. Because of the corrections, Bulletin 99 - 43, *Coverage of RotaShield ® (rotavirus vaccine, live, oral, tetravalent),* published April 1999, and the Rotashield criteria on the Drug Criteria & Limits List dated April 1999 are now obsolete.

Interferon Beta

Interferon Beta-1A, 33 mcg., code J1825, is covered by Medicaid effective January 1, 1999. Bulletin 99 - 35, *Injectable Medications (J - Codes),* published January 1999 included code J1825 in error in the group of non-covered codes. Interferon Beta-1A is covered and is added to the Injectable Medications List.

Herceptin, Synagis, Respigam

The products Herceptin, Synagis, and Respigam are covered, but do not yet have an assigned J-code. As per instructions on the Injectable Medications List, use code J3490, unclassified drug, to bill. These products cannot be billed through the pharmacy program with an NDC code.

Herceptin: Each vial may be used for multiple patients who use a dose measured in milligrams (mg).

Synagis: As of May 1999, the direct purchase price is $938.00. The Medicaid reimbursement for this product is $1,031.80.

Billing Instructions Clarified

There are billing instructions on page 1 of the Injectable Medications List for codes J3490 and J3999. The instructions are clarified to include billing both electronically and on a paper claim form.

Updating the Injectable Medications List

The products listed in this bulletin and specific coverage criteria are added to the Injectable Medications List. Providers of physician services will find pages attached to update this list. Because there are other page corrections for the Physician Services Manual, the instructions for replacing pages are in Bulletin 99 - 72, *Physician Services Manual Updates*.

Drugs Billed by Prescribers Removed from Drug Criteria and Limits List

Beginning July 1999, products billed by prescribers will be included only on the Injectable Medications List. Drugs billed by pharmacists will be included only on the Drug Criteria and Limits List. Consequently, the criteria for Synagis, Respigam, and RotaShield have been removed from the Drug Criteria and Limits List. For more information, refer to Bulletin 99 - 62, *Drugs Moved from the Drug Criteria & Limits List to the Injectable Medications List*. □

99 - 65 Laparotomy Procedure Code Corrections

Laparotomy policy and associated codes have been reviewed to clarify which codes to pay and which to deny. The Utah Medicaid Provider Manual for Physician Services, Section 2, Physician Services, Chapter 3, LIMITATIONS, item t, Exploratory laparotomy, is corrected to remove the word "full" from the second sentence. A second sentence is added regarding additional surgical procedures. The new sentence is as follows:

> "When additional surgical procedures, identified and billed by separate identifiable procedure codes, are completed in addition to the laparotomy, reimbursement for the laparotomy will be denied. The additional procedures will be reimbursed in accordance with the multiple procedure methodology."

Physician Services Manual Updated

Section 2, Physician Services, Chapter 3, is updated as described in the paragraph above. Because there are other pages revised in Section 2, the instructions for replacing pages are in Bulletin 99 - 72, *Physician Services Manual Updates*. ☐

99 - 66 Aquatic Therapy Not Covered

CPT code 97113, aquatic therapy with therapeutic exercise, is not covered by Medicaid. This code is added as non-covered to page 52 of the Medical and Surgical Procedures Code List which is included with the Utah Medicaid Provider Manual for Physician Services. (Code 97113 was a new code in 1995 and has not ever been covered by Medicaid.)

To economize on printing and mailing costs, the corrected page 52 is not attached. If you want the updated list with code 97113 included as non-covered, please contact Medicaid Information. (See box at bottom of page.) Ask for the July 1999 Medical and Surgical Procedures Code List. ☐

99 - 67 Medical Supplies Purchased by Medicaid Must Be New and Unused

Medical supplies purchased under the Medicaid program must be new, unused equipment. Payment is for new equipment, and the medical supplier must be able to furnish invoices showing that the equipment is new. Refurbished, rebuilt, or used equipment is not acceptable for purchase by Medicaid, unless specifically authorized in writing for an individual piece of equipment or unless specifically allowed under contract with the Division of Health Care Financing.

The policy statement above will be added to page 19 of Section 2 of the Utah Medicaid Provider Manual for Medical Suppliers, Chapter 4, PURCHASE OR RENTAL OF EQUIPMENT, as item number 1. The original items 1 and 2 will be renumbered as 2 and 3.

If you would like an updated Section 2 with this revision included, contact Medicaid Information. Ask for Section 2 of the Medical Suppliers Manual dated July 1999.

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99 - 68 Podiatry Code Reopened

Code Y8025, office surgery kit, continues to be a covered code for podiatrists only. This code is added to Section 2 of the Utah Medicaid Provider Manual for Podiatric Services, page 19, in the group of miscellaneous codes. An index for Section 2 has been added as well. Podiatrists will find attached two pages to update Section 2. Remove pages 18 - 19 dated April 1999 and replace with the attached pages 18 through 20.

Other providers who want this revision should use the Publication Request Form attached or call Medicaid Information. ☐

99 - 69 Emergency Services Program

The Emergency Services Program is a program for individuals who do not meet United States citizenship requirements, but who meet all other Medicaid eligibility criteria. When a client's Medicaid Identification Card states "EMERGENCY SERVICES," the client is **not** eligible for a full range of Medicaid benefits. Instead, the client is eligible for only those benefits which meet Medicaid's definition of emergency services as defined in the paragraph below.

An example of the Emergency Services Medicaid Identification Card is shown to the right.

OFFICE OF FAMILY SUPPORT
158 SOUTH 200 WEST
P.O. BOX 45490
SALT LAKE CITY UT 84145

NON-NEGOTIABLE

NON-NEGOTIABLE

JANE DOE
1234 FIRST STREET
ANYTOWN UT 84000

NON-NEGOTIABLE

MEDICAID IDENTIFICATION CARD
UTAH DEPARTMENT OF HEALTH

ELIGIBLE FROM - JULY 1, 1999 THRU JULY 31, 1999
THIS ID CARD ENTITLES THE FOLLOWING NAMED PERSONS TO EMERGENCY SERVICES ONLY.

EMERGENCY SERVICES EMERGENCY SERVICES

NAME	ID	SEX	DOB	AGE
DOE, JANE	9999999999	F	01APR60	39

CLIENT: THIS CARD IS ONLY VALID FOR EMERGENCY SERVICES. ANY ATTEMPT TO MODIFY THIS CARD IN ANY WAY OR ALLOW USE BY UNAUTHORIZED PERSONS CONSTITUTES FRAUD.

PROVIDER: THIS CARD IS VALID FOR EMERGENCY SERVICES ONLY (AS DEFINED IN SECTION 1 OF YOUR PROVIDER MANUAL) ALL SERVICES WILL BE REVIEWED PRIOR TO PAYMENT BY THE DIVISION OF HEALTH CARE FINANCING. IF YOU HAVE QUESTIONS OR NEED INFORMATION, PLEASE CALL THE MEDICAL INFORMATION UNIT AT 538-6155 OR CALL TOLL FREE 1 (800) 662-9651. IF YOU HAVE ANY CHANGES IN YOUR INSURANCE CALL THE TPL UNIT AT 536-8798 (TEAM 76) OR TOLL FREE 1 (800) 821-2237. FOR THIRD PARTY LIABILITY INFORMATION CALL THE TPL UNIT AT 536-8798 (TEAM 76) OR TOLL FREE: 1 (800) 821-2237. THIS IS THE END OF THE MEDICAID IDENTIFICATION CARD.**********000191919 EM

Emergency Services Defined

"Emergency" shall mean a medical condition for which the absence of immediate medical attention could reasonably be expected to result in death or permanent disability to the person, or in the case of a pregnant woman, to the unborn child. Emergency services shall be those rendered from the moment of onset of the emergency condition, to the time the person's condition is stabilized at an appropriate medical facility, or death results. The definition of emergency services shall include labor and delivery services, but not prenatal or post-partum services.

Emergency services shall not include prolonged medical support, medical equipment or prescribed drugs which are required beyond the point at which the emergency condition has been resolved. Emergency services also shall not include long term care or organ transplants.

Emergency Services - Labor and Delivery

Only labor and delivery services are covered. Prenatal and postpartum services are NOT covered for individuals eligible for the Emergency Services Program. Physicians and Certified Nurse Midwives may use only the non-global delivery codes listed to bill for labor and delivery services.

1. Physicians may be reimbursed for the following procedure codes:
   - High Risk delivery

     Y7052, High-risk delivery only.

     Y7053, High-risk delivery only, Cesarean

   - All other deliveries described by the following CPT procedure codes: 59409, 59514, 59612, 59620

2. Services by Certified Nurse Midwife
   A Certified Nurse Midwife may be reimbursed for a delivery described by the following procedure code: Y0607, Vaginal delivery only and postpartum care with or without forceps.

All Other Services Require Documentation

Four steps are required to consider payment for a claim for services to an individual who qualifies for Emergency Services.

1. The provider bills the claim to Medicaid.

2. When a claim is denied pending receipt of documentation and approval by Medicaid, a remittance advice is sent to the provider. Only emergency services for labor and delivery are paid without documentation.

3. If a provider receives the remittance advice stating payment was denied, **FAX** or **mail** to Medicaid a copy of the remittance advice and medical reports or other documentation to justify the services qualified as an emergency. Do NOT rebill the claim!

   The FAX number is (801) 536-0475. Use the mailing address for Medicaid Operations claims.

   Bureau of Medicaid Operations
   P.O. Box 143106
   Salt Lake City, UT 84114-3106

4. Medicaid staff review the documentation. If services are approved as an emergency, the claim is reprocessed and paid. A second remittance advice is mailed to confirm payment.

Provider Manuals Updated

Three sections of the Utah Medicaid Provider Manual are updated to clarify billing for the Emergency Services Program: Section 1, General Information; Section 2, Physician Services; and Section 2, Certified Nurse Midwife Services.

Section 1, General Information

Chapter 4 - 1, *Emergency Services* is revised to clarify coverage. The third paragraph is amended as follows:

"Only emergency services for labor and delivery are paid without documentation. All other services provided to a patient with an Emergency Services Card will be reviewed by the Division of Health Care Financing prior to payment."

The following sentence is added as a final sentence in Chapter 4 - 1: "For information on billing and processing for claims under the Emergency Services Program, refer to Chapter 11 - 11, *Emergency Services Program*."

A new Chapter 11, *Billing Claims*, is added to Chapter 11, *Billing Claims*. The addition is as follows:

"This chapter concerns billing claims for an individual eligible for the Emergency Services Program. For an explanation of eligibility requirements and coverage, refer to Chapter 4 - 1, *Emergency Services Program.*

1. Physicians and Certified Nurse Midwives may use only the non-global delivery codes specified in Section 2 to bill for labor and delivery services for an individual eligible for the Emergency Services Program.

2. All services other than labor and delivery require documentation.

Four steps are required to consider payment for a claim for services to an individual who qualifies for Emergency Services.

A. The provider bills the claim to Medicaid.

B. The claim is automatically denied pending receipt of documentation and approval by Medicaid. A remittance advice is sent to the provider. Only emergency services for labor and delivery are paid without documentation.

C. When the provider receives the remittance advice stating payment was denied, **FAX** or **mail** to Medicaid a copy of the remittance advice and medical reports or other documentation to justify the services qualified as an emergency. Do NOT rebill the claim!

   The FAX number is (801) 536-0475. Use the mailing address for Medicaid Operations claims.

D. Medicaid staff review the documentation. If services are approved as an emergency, the claim is reprocessed and paid. A second remittance advice is mailed to confirm payment."

Section 2, Physician Services

Section 2 of the Utah Medicaid Provider Manual for Physician Services is updated to add two new paragraphs under Chapter 2, COVERED SERVICES, Maternity Care, Labor and Delivery (page 10). The new paragraphs are as follows:

"**Only labor and delivery codes are billable for an individual with an Emergency Services card.** Other maternity care services (prenatal and postpartum) are not payable as an emergency. Physicians may be reimbursed for the following procedure codes under the Emergency Services Program:

- High Risk delivery: Y7052, High-risk delivery only, or Y7053, High-risk delivery only, Cesarean

- All other deliveries described by the following CPT procedure codes: 59409, 59514, 59612, 59620

For more information on the Emergency Services Program, refer to Section 1, General Information."

Because there are other pages corrected in Section 2, the instructions for updating page 10 are in Bulletin 99 - 72, *Physician Services Manual Updates*.

Section 2, Certified Nurse Midwife Services.

Certified Nurse Midwives will find attached two pages to update Section 2, Certified Nurse Midwife Services. On page 4, a second paragraph is added under Chapter 2, LIMITATIONS. The new subparagraph is as follows:

"A. Emergency services for labor and delivery

Only labor and delivery codes are billable for an individual with an Emergency Services card. Other maternity care services (prenatal and postpartum) are not payable as an emergency. A Certified Nurse Midwife may be reimbursed for a delivery described by the following procedure code: Y0607, Vaginal delivery only and postpartum care with or without forceps.

For more information on the Emergency Services Program, refer to Section 1, General Information."

An Index is added to the end of Chapter 2 as a new page 16.

Questions?

This bulletin updates and replaces Bulletin 96-77, *Emergency Services Program*, issued in October 1996. If you have a question about the Emergency Services program, please call Medicaid Information. □

99 - 70 Payer Specific Instructions for HCFA-1500 Claims Discontinued

Standards for the HCFA-1500 Claim Form are available from the insurance commissioner and through the Utah Health Information Network (UHIN) web site: http://www.uhin.com/uhin. UHIN also provides the software required to bill electronically. Therefore, the Utah Medicaid agency is discontinuing issuing payer specific billing instructions for the HCFA-1500 Claim Form.

Please cross out or remove instructions for HCFA-1500 Claims which are in the General Attachments Section of the Utah Medicaid Provider Manual. Providers who use the paper claim form should contact the Utah Health Information Network (UHIN) for standard instructions. Providers may call Doreen Espinoza at (801) 466-7705. □

99 - 71 Mailing Address Reminder

It has been a year now since the Medicaid post office box changed. As of July 1, 1999, the postal service will begin returning any incorrectly addressed mail. If you haven't already made the switch, now would be a good time to make sure your claims are being sent to the correct Post Office box.

Bureau of Medicaid Operations
P.O. Box 143106
Salt Lake City, Utah 84114-3106

99 - 72 Physician Services Manual Updates

Physicians, osteopaths, and licensed nurse practitioners will find attached pages to update the Utah Medicaid Provider Manual for Physician Services Each page has a revision date at the top right side of the page to indicate the month in which the change is effective. A vertical line is placed in the margin next to text which has changed. Specific instructions below include a reference to the bulletin article which explains the policy change.

♦ **Table of Contents for Sections 2 through 4:** The table is updated to show most recent date of issue of Special Attachments to the Physician Services Manual.

♦ **Section 2, Physician Services:** The page changes below are in Section 2.

- Remove original page 1 and replace with page 1 attached, dated July 1999. Page numbering on the Table of Contents is changed to accommodate pages added.
- Add four pages to Chapter 2, Covered Services:
  Pages 10 - 11: Refer to Bulletin 99 - 59, *Telehealth for Special Health Care Needs Children Project*
  Pages 12 - 13: These two pages are reserved for future use.
- Remove original pages 10 - 11 and replace with pages 14 - 15 attached, dated July 1999. Refer to Bulletin 99 - 69, *Emergency Services Program*.
- Renumber the original pages 12 through 15 as pages 16 through 19.
- Remove pages 16 - 17 (original numbering). Replace with updated pages 20 - 21. For information on the correction to item T on page 20, refer to Bulletin 99 - 65, *Laparotomy Procedure Code Corrections*. For information on the addition of item HH, Neonatal Care on page 21, refer to Bulletin 99-57, *Attendance at Delivery and Neonatal Resuscitation*. Note: Numbering of items AA through GG is also corrected on page 21.
- Renumber former pages 17A through 22 as pages 22 through 28.

♦ **Section 4, Laboratory Services:** The page changes below are in Section 4.

- Two new pages are added to Chapter 2, COVERED SERVICES, as per Bulletin 99 - 58, *Laboratory Tests for Dialysis Patients*. Remove pages 6 - 7 and replace with pages 6 through 9 attached.
- Renumber the original pages 8 through 10 as pages 10 through 12. (Note: An Index for Section 4 has been added as a new page 13, but to economize on printing and mailing costs, page 13 is not attached. Providers requesting an updated Section 4 will receive the July 1999 edition which includes page 13.)

♦ **Updated Lists included with the Physician Manual**

- Drug Criteria & Limits List:
  – Remove original pages 7 - 8 and replace with pages 7 -8 attached. Page 8 is corrected to change the criteria for amphetamines for children ages 3 through 18, as per Bulletin 99 - 60, *ICD-9 Code Required on Pediatric Prescriptions for Amphetamines*.
  – On page 13, cross out the criteria for Synagis and Respigam. On page 15, cross out the criteria for RotaShield. The criteria for these products were moved to the Injectable Medications List, as per Bulletin 99 - 62, *Drugs Moved from the Drug Criteria & Limits List to the Injectable Medications List*.
- Injectable Medications List: Remove original pages 1, 4 - 5, 6 - 7, 10 - 11, and 14 - 15. Replace with the same corrected pages attached and add pages 16 through 18. Page 1 expands billing instructions for both electronic and paper claims. Products listed in Bulletin 99 - 64, *Injectable Medications Covered: Interferon Beta-1A, Herceptin, Synagis, Respigam, Rotashield*, are added to the Injectable Medications List. Q codes are removed, as per Bulletin 99 - 63, *Q Codes Not Covered*. The criteria for products listed on pages 16 through 18 are added as per Bulletin 99 - 62, *Drugs Moved from the Drug Criteria & Limits List to the Injectable Medications List*.
- Medical and Surgical Procedures List:
  – Remove original pages 57 - 58; replace with updated pages 57 - 58 attached.
  – Add pages 77 - 78 with Criteria #30 (Neonatal Care) as per Bulletin 99-57, *Attendance at Delivery and Neonatal Resuscitation*.
- Over-the-Counter Drug List: Remove the original list and replace with the list attached: Bulletin 99 - 61,*Over-the-Counter Drug List Updated*. ☐

Requesting a Medicaid publication or form?
Send the Publication Request Form attached.
- by FAX: 1-801-538-6805
- by mail to:
  Division Of Health Care Financing
  Box 143106
  Salt Lake City UT 84114-3106

INTERNET SITE: http://www.health.state.ut.us/medicaid

Medicaid Information
- Salt Lake City area, call **538-6155**.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free **1-800-662-9651**.
- From other states, call **1-801-538-6155**.

99 - 73 Psychology Services Manual Updated

Section 2 of the Utah Medicaid Manual for Psychology Services is updated. This bulletin briefly describes the revisions. Psychologists will find attached pages 1 through 11. Instructions for replacing pages in the manual are at the end of this bulletin.

Pages 2 - 3: Chapters 1 through 1 - 3
Clarifications of existing policy.

Page 4: Chapter 2 - 1, Initial Evaluation

Effective July 1, 1999, prior authorization is required for the initial evaluation.

Information in this chapter specifying that ***ongoing*** evaluation requested by the Division of Services to People with Disabilities (DSPD) to reassess a diagnosis of mental retardation or developmental disability and current functioning level was not the responsibility of the child's HMO is deleted. HMOs are responsible for ***all*** evaluation and testing, including neuropsychological testing, for CHEC-eligible children with a developmental disorder or organic disorder.

Two changes are made in the **Unit** section:
Procedure code Y3205 is now limited to foster care children referred by the Division of Child and Family Services (DCFS). Separate procedure codes have been established for the initial evaluation for foster care children referred by the Division of Youth Corrections (DYC) and for children referred by DSPD.

The new procedure codes are:
Y3206 Initial evaluation for foster care children referred by DYC
Y3207 Initial evaluation for children referred by DSPD

Another limitation is added under the **Limits** section:
"D. The initial evaluation for children with a developmental disorder or organic disorder who are enrolled in an HMO is covered by the HMO."

Page 5: Chapter 2 - 2, Additional Evaluation Hours

Three changes are made in the **Unit** section:
Procedure code Y3215 is now limited to foster care children referred by DCFS. Separate procedure codes have been established for additional evaluation hours for foster care children referred by DYC and for children referred by DSPD.

The new procedure codes are:
Y3208 Additional evaluation per hour for foster care children referred by DYC
Y3209 Additional evaluation per hour for children referred by DSPD

Another limitation is added under the **Limits** section:
"B. Additional evaluation hours for children with a developmental disorder or organic disorder who are enrolled in an HMO are covered by the HMO."

Page 5: Chapter 2 - 3, Psychological Testing

Two changes are made in the **Unit** section:
Procedure code Y3225 is now limited to foster care children referred by DCFS. Separate procedure codes have been established for psychological testing for foster care children referred by DYC and for children referred by DSPD.

The new procedure codes are:
Y3211 Total psychological testing for foster care children referred by DYC
Y3212 Total psychological testing for children referred by DSPD

Another limitation is added under the **Limits** section:
"C. Psychological testing, including neuropsychological testing, for children with a developmental disorder or organic disorder who are enrolled in an HMO, is covered by the HMO."

Page 6: Chapter 2 - 4, Individual Therapy

Two changes are made in the **Unit** section:
Procedure code Y3235 is now limited to foster care children referred by DCFS. Separate procedure codes have been established for individual therapy for foster care children referred by DYC and for children referred by DSPD.

The new procedure codes are:
Y3213 Individual therapy per hour for foster care children referred by DYC
Y3214 Individual therapy per hour for children referred by DSPD

Page 6: Chapter 2 - 5, Group Therapy

Two changes are made in the **Unit** section:
Procedure code Y3245 is now limited to foster care children referred by DCFS. Separate procedure codes have been established for group therapy for foster care children referred by DYC and for children referred by DSPD.

The new procedure codes are:

Y3216 Group therapy per hour for foster care children referred by DYC

Y3217 Group therapy per hour for children referred by DSPD

Page 8: Chapter 3, PRIOR AUTHORIZATION

Change the first sentence of Chapter 3, PRIOR AUTHORIZATION, to state, "Prior authorization is required for all services." The former exception is deleted. Also, correct the name and address of the Medicaid Bureau from which to request written proper authorization to the following: *(The corrections are underlined in the address below.)*

Bureau of Managed Health Care
Division of Health Care Financing
Box 143108
Salt Lake City UT 84114-3108

Page 9: Chapter 3 - 1, Specific Prior Authorization Criteria

This chapter is revised in its entirety. Prior authorization criteria are added for the initial evaluation. Item A, Prior authorization criteria for the initial evaluation, now states:

"Prior authorization for the initial evaluation may be granted if the psychologist documents the need for an evaluation to:

1. identify the existence, nature or extent of psychological impairment or deterioration of functioning; and
2. determine the need for medically necessary services."

Item B now contains prior authorization criteria for addition units of evaluation. Item C now contains prior authorization criteria for psychological testing, and item D now contains criteria for individual and group therapy.

Page 10: Chapter 4, PROCEDURE CODES FOR PSYCHOLOGY SERVICES

A note is added that prior authorization is required for all services. The list is revised to include the new codes and code description changes listed in this bulletin.

Page 11: Index added for Section 2

Updating the Psychology Services Manual

Attached to this bulletin are pages 1 through 11 of Section 2 of the Utah Medicaid Provider Manual for Psychology Services. Remove the earlier Section 2 and replace with the Section 2 attached. The date at the upper right of the page indicates the date the page was revised. A vertical line is placed in the margin next to text which changed with this update. An asterisk (*) marks where text was deleted.

Section 2 was last updated in November 1997. For more information about the updates made in November 1997, refer to Bulletin 98 - 14, *Psychology Services Manual Updated*. The bulletin was published in January 1998 and listed revisions to five chapters.

If you need an updated Section 2 and did not receive one, contact Medicaid Information. Ask for Section 2 of the Psychology Services Manual dated July 1999. ☐

99 - 74 Hospital Manual: Rule Citations Corrected

A rule citation in the Utah Medicaid Provider Manual for Hospital Services is clarified. The change is in Section 2, Hospital Services, Chapter 2, COVERED SERVICES. The first sentence on page 8 is corrected as indicated by the changes in bold print in the sentence below.

"All hospital inpatient and outpatient services are subject to review by the Department of Health for **medical necessity** and appropriateness **of the admission** according to R414-1-12 and **R414-1-14 of the** Utah Administrative Code**."**

A similar statement which appears under item 1, *Inpatient Hospital* services. . . , Inpatient Stay Defined, is deleted.

Replacement Page for Section 2

Attached to this bulletin is a replacement page for Section 2. Remove existing pages 8 - 9 in Section 2 and replace with the attached pages 8 - 9. A vertical line is placed in the margin next to text which has changed. An asterisk (*) indicates where text was deleted. ☐

99 - 75 Outpatient Physical Therapy Services by an Independent Physical Therapist NOT Associated with a Rehabilitation Center

Effective August 1, 1999, the existing physical therapy codes may only be billed for services by a private or independent physical therapist, including a group practice, who is not associated with a rehabilitation center with physical and occupational therapists and a treatment planning team or committee. This change is because as of August 1, 1999, Medicaid will implement a separate program for physical therapy services in a rehabilitation center. Bulletin 99 - 82, *Physical Therapy and Occupational Therapy Services in Rehabilitation Centers*, addresses services by therapists associated with a rehabilitation center.

Physical Therapy Services Manual Amended

The current Utah Medicaid Provider Manual for Physical Therapy Services will be amended August 1, 1999, to apply ONLY to services by an independent physical therapist. Changes are described briefly below:

- The name of the manual and Section 2 will be changed to the Utah Medicaid Provider Manual for Physical Therapy Services by Independent Physical Therapists NOT in a Rehabilitation Center.
- Section 2, Chapter 1, GENERAL POLICY, is amended to add a new second paragraph explaining that the policy applies only to independent physical therapists. Physical therapists in rehabilitation centers must refer to Section 2 titled Physical Therapy and Occupational Therapy Services in Rehabilitation Centers.
- A new item is added to Section 2, Chapter 2 - 2, *Limitations*, to state that physical therapists in rehabilitation centers must refer to Section 2 titled Physical Therapy and Occupational Therapy Services in Rehabilitation Centers.

Physical therapists will find attached five pages to update their provider manuals effective August 1, 1999. Remove the original pages 1, 2 - 3, 8 - 9 and 10 - 11 in Section 2 and replace with the pages attached. Remove the original pages 1 - 2 of the list of procedure codes and replace with the page attached. If updated pages are not attached, and you want a copy, please contact Medicaid Information. ☐

99 - 76 Outpatient Occupational Therapy Services for Adults

Medicaid will begin covering outpatient occupational therapy for adults beginning August 1, 1999. Services under this program will be paid from the funds allocated to the physical therapy program and only if the Medicaid agency (the Division of Health Care Financing) would have paid for physical therapy services on July 31, 1999, for the diagnosis.

Occupational therapy (O.T.) services will be covered for two provider types: independent occupational therapists and rehabilitation centers. This remainder of this bulletin addresses services by a private, independent occupational therapist, including a group practice, who is not associated with a rehabilitation center with physical and occupational therapists and a treatment planning team or committee. Occupational therapists associated with a rehabilitation center should refer to Bulletin 99 - 82, *Physical Therapy and Occupational Therapy Services in Rehabilitation Centers*, for information on coverage and criteria.

O.T. Services Covered and Procedure Codes

All O.T. services for adults age 21 years and older* by an independent occupational therapist must be prior authorized by Medicaid. Services are limited to the following diagnoses: CVA, traumatic brain injury, spinal cord injury, hand injury, birth defects and neurodevelomental deficits. The procedure codes listed below for O.T. services for adults may only be billed by an independent occupational therapist:

Y5302	Evaluation
Y5303	Bundled codes for all treatment modalities. All services require prior authorization.

*For outpatient O.T. services for children under 21 years of age, use the Child Health and Evaluation and Care (CHEC) program O.T. codes. Refer to the Utah Medicaid Provider Manual for Child Health and Evaluation and Care Services.

New Manual Issued for Occupational Therapy Services

Occupational therapists will find attached the Utah Medicaid Provider Manual for Occupational Therapy Services by Independent Occupational Therapists NOT in a Rehabilitation Center. Policy is effective August 1, 1999. Other providers who would like a copy should contact Medicaid Information. ☐

99 - 77 Waiver Service Providers for Individuals Aged 65 and Older: Time Limit to Submit Claims Limited to 90 Days

Effective July 1, 1999, Medicaid providers billing under a Provider Number for the 1915(c) Home and Community-Based Services Waiver for Individuals 65 and Older (the Aging Waiver) must submit a claim for payment no later than 90 days from the actual date of service in order for the claim to be eligible for payment.

THIS CHANGE ONLY AFFECTS CLAIMS FOR THOSE SPECIFIC SERVICES COVERED BY THE HOME AND COMMUNITY-BASED WAIVER PROGRAM AND BILLED UNDER THE PROVIDER NUMBER ASSIGNED FOR THE AGING WAIVER. Claims for State Plan services provided to Medicaid recipients who also participate in the Aging Waiver may continue to be submitted up to 12 months from the date of actual service.

The allowable time frame within which a claim may be filed is being reduced from 12 months to 90 days in order to effectively manage the Aging Waiver's established annual budget allocation, to assure funds available during each fiscal year are properly allocated to eligible Medicaid recipients, and to provide an increased level of quality oversight for the care plan implementation process.

If you have any questions concerning these changes, please call Ruedell Sudweeks at 538-6636. To call toll-free, call Medicaid Information; ask to be transferred to Ruedell Sudweeks at extension 86636.

Policy Manual Change

Waiver service providers for persons 65 and older will find attached pages 1 and 22 - 23 to update the Utah Medicaid Provider Manual for Home and Community Based Waiver Services for Persons 65 and Older. Remove the original pages 1 and 22 - 23 and replace with the revised pages attached.

The Table of Contents on page 1 is revised to include a new Chapter 6. On page 22, the new Chapter 6 is added: *Time Limit to Submit Claims*.

Former Chapter 6, *Service Procedure Codes*, is renumbered as Chapter 7. Four procedure codes announced in two previous bulletins are added to Chapter 7. The codes are described briefly below.

Y0524, Assessment (areas along the Wasatch Front), and Y0525, Assessment (areas outside of Wasatch Front). These codes became effective December 1, 1997, as announced by Bulletin 98 - 19, *New Procedure Codes for Home and Community-Based Waiver Services for Individuals Aged 65 and Over*, published in January 1998.

Two codes added with prior authorization - Y0526, Respite Care--Homemaker, and Y0527, Respite Care--Home Health Aide, were announced by Bulletin 98 - 37, *New Procedure Codes for Home and Community-Based Waiver Services for Individuals Aged 65 and Over*, published in April 1998. □

99 - 78 Utah Medicaid is Prepared for Y2K

Utah Medicaid became actively involved in the Year 2000 issue in late 1996. Programming was completed and implemented from 1998 through March 1999. Extensive validation testing, including a review by HCFA and a private independent verification and validation vendor, has been completed. Validation testing is currently being done with several providers at their request. A Y2K contingency planning team is in place, and will continue to meet and update the contingency plan.

Some providers have asked if there will be billing changes in conjunction with Y2K. Utah Medicaid uses standard electronic claim formats and standard claim forms. There is no change expected related to Y2K except that the universal (NCPDP) pharmacy claim form is being modified by the national committee. We expect no changes in the system of payments or the appearance of the paper or electronic remittance statements. There will be more information in future Medicaid Information Bulletins. □

99 - 79 Year 2000 Advisories

Both the federal Health Care Financing Administration (HCFA) and the Utah Medicaid agency, the Division of Health Care Financing, are committed to ensuring that Medicaid clients continue to receive high quality care, and that you continue to be paid accurately and promptly, into the Year 2000.

In April 1999, we issued four bulletins regarding Year 2000 (Y2K) preparedness. The abstracts which follow describe each of these bulletins. You can obtain a copy of any or all of these bulletins from the Internet or from Medicaid.

The Internet source for these documents is the April 1999 bulletin:

http://www.health.state.ut.us/medicaid/April1999.pdf.

The Y2K bulletins are on pages 19 through 22. NOTE: This bulletin is in Adobe Acrobat format. If you do not yet have the FREE Adobe Acrobat Reader installed on your personal computer, please refer to Bulletin 99- 55, *Medicaid Bulletins Now in Acrobat Reader*.

The other way to obtain a copy of these bulletins is to contact Medicaid information. Ask for the April 1999 Medicaid Information Bulletin.

Y2K Bulletin Abstracts

Bulletin 99 - 50, Y2K Talking Points for HCFA Activities

This bulletin is a Y2K briefing issued by the federal Health Care Financing Administration (HCFA). The original briefing, Year 2000 Provider Outreach Activities, is on the Internet at http://www.hcfa.gov/y2k. IT covers such topics as:

- What Is the Year 2000 (Also Known as the Y2K) Challenge and Why Is it Important?
- What Is HCFA'S Plan to Be Y2K Ready?
- What Resources Has HCFA Committed to Y2K Compliance?
- Will HCFA Systems Function in the Year 2000?

Bulletin 99 - 51, Federal Y2K Biomedical Equipment Clearinghouse

This bulletin announces a World Wide Web database with information on the Year 2000 compliance of medical devices, scientific laboratory equipment and biomedical equipment. The U.S. Food and Drug Administration established the database to provide comprehensive and up-to-date information on products which may have Y2K problems. The database, called the Federal Y2K Biomedical Equipment Clearinghouse, can be accessed at http://www.fda.gov/cdrh/yr2000/y2kintro.html.

Bulletin 99 - 52, FDA Medical Device Malfunction Advisory:

This bulletin reiterates a warning from the FDA to health care practitioners that computer date malfunctions may already affect some medical devices. There are two products with verified problems: the Hewlett-Packard 43100A/43200A external defibrillator and the Invivo Research Inc.'s Millennia 3500 multiparameter patient monitor. There may be other devices with similar, unidentified date-related problems. Health care providers should be alert to the date display, printing of dates, device records and date recording of medical devices, especially on or after January 1. The FDA's address and toll-free number (1-888-INFO-FDA ; 1-888-463-6332) are provided, as well as information about MedWatch, the voluntary program for reporting problems to the FDA.

Bulletin 99 - 53, Director's Memo to Medicaid Providers

This bulletin is a memo from Michael Deily, Director of the Division of Health Care Financing, to health care practitioners. The memo explains how the Y2K computer problem may affect practitioners and patients. Key points covered are testing of the Medicaid claims processing systems; contingency plans; assessing and ensuring readiness of providers' billing systems, practice and facility; developing business contingency plans for critical operations; and a sample Provider Y2K Readiness Checklist.

□

99 - 80 Medicaid Payments Will Not be Delayed by Y2K Issues

The Utah Medicaid program has been involved with Y2K issues since 1996. Each of the Medicaid Management Information System (MMIS) sub-systems have been reviewed by federal staff and their contractors. The Division of Health Care Financing has also used contractors to review the computer code for each of the MMIS sub-systems. The project was completed in March 1999.

We have also been in contact with the federal government on the Y2K issue to make sure that the Utah Medicaid program will be able to make payments to nursing homes, hospitals and other providers for Medicaid services. The nature of the contact was to make sure that federal funds which make up the majority of Medicaid dollars will be available to be transferred to the state. We are not aware of any problem that would cause delay of payment to providers of Medicaid services on and after January 1, 2000.

Normal contingency plans are in effect that have been used and tested in the past that will make sure that no payment delays will take place. We are planning on paying nursing homes on the same basis that we currently are doing. The same will be done for hospitals and other Medicaid providers. ☐

99 - 81 Audiology: Criteria for Hearing Aids; Brain Stem Testing

Policy and procedure codes for audiology and hearing aid services have been updated. Audiologists will find attached pages 1 through 14 of Section 2 of the Utah Medicaid Provider Manual for Audiology Services. To update the manual, remove the old section 2, pages 1 - 10 and replace with the pages attached. On the revised pages, a vertical line is placed in the margin next to text which has changed. Changes are described briefly in the remainder of this bulletin. For complete information, refer to the revised Section 2.

Note to hearing aid specialists: We are not able to identify, for mailing purposes, other providers such as hearing aid specialists who should also receive the new Section 2. If you want a copy of the new Audiology policy, and Section 2 is not attached, please call Medicaid Information; ask for Section 2 for Audiology Services.

Chapter 1, AUDIOLOGY SERVICES

- Reference to Utah Administrative Code R414-59 Audiology-Hearing Services added to end of first paragraph.
- Additions of Chapters 1 - 3, Client Enrolled in a Managed Care Plan, and 1 - 4, Client NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Chapter 2, COVERED SERVICES

- Former subsections 1 through 3 of Chapter 2, renumbered as 2 - 1 through 2-3.

Chapter 3, LIMITATIONS

- Former chapter 2-3, Limitations, renumbered as Chapter 3, Limitations.
- Former subsections 1 and 2 renumbered as 3 - 1 and 3 - 2.

Chapter 4, HEARING AID REPLACEMENT AND REPAIRS

- Addition of new Chapter heading Hearing Aid Replacement and Repairs.
- Former items 3 and 4 renumbered as Chapters 4 - 1 and 4 - 2.

Chapter 5, PRIOR AUTHORIZATION

- Former Chapter 3, PRIOR AUTHORIZATION, renumbered as Chapter 5.
- Subsection 1 renumbered as 5 - 1 and item 2 revised.
- Newly renumbered subsection 5 - 2 is revised in its entirety. The revision distinguishes between criteria for hearing aids for clients age 18 and older and those age 17 and younger.

Chapter 6, PROCEDURE CODES

- Former Chapter 4, PROCEDURE CODES, renumbered as Chapter 6.

– Criteria for codes Y5030 , Monaural Hearing Aid, global charge, and Y5130, Binaural Hearing Aid, global charge, revised in accordance with policy in Chapter 5, PRIOR AUTHORIZATION, Subsection 5 - 2.
– Subsection 5 - 2 contains a new item on brain stem testing.

□

99 - 82 Physical Therapy and Occupational Therapy Services in Rehabilitation Centers

Effective August 1, 1999, Medicaid will implement a new program for physical therapy and occupational therapy (P.T./O.T.) services in a rehabilitation center with both types of therapists and a treatment planning team or committee. This bulletin briefly describes the new program. For additional information, refer to Section 2 of the new Utah Medicaid Provider Manual for Physical Therapy and Occupational Therapy Services in Rehabilitation Centers.

Medicaid is in the process of enrolling rehabilitation centers which apply to become Medicaid providers. Once a center is enrolled, a copy of the new provider manual is issued to the rehabilitation centers. If you want a copy of the new manual, please call Medicaid Information; ask for Section 2 for Physical Therapy and Occupational Therapy Services in Rehabilitation Centers.

Services Covered in Rehabilitation Centers

The rehabilitation center or clinic must enroll as a Medicaid provider for P.T./O.T. rehabilitation centers and bill for services. An individual therapist may not bill for services. Services are limited to the following diagnoses: CVA, Traumatic Brain Injury, Spinal Cord Injury, Hand injury, Birth Defects and Neurodevelomental deficits.

The rehabilitation center or clinic must receive the rehabilitation request from a physician. The treatment planning committee assigns the P.T./O.T. treatments according to standard P.T./O.T. protocols for the diagnosis. The evaluation and first ten visits do not require prior authorization. The rehabilitation center must request prior authorization for any additional treatments using the bundled code Y5306.

Procedure Codes

The Physical Therapy and Occupational Therapy Services Program in Rehabilitation Centers is similar to the Physical Therapy program for independent therapists, but different codes must be used for billing services. Procedure codes which may be billed by a rehabilitation center for P.T./O.T. services are listed below.

Y5304 Evaluation
Y5305 First ten treatment visits. May be a combination of P.T. and O.T. The first ten treatment visits do not require prior authorization.
Y5306 Additional treatments after the first ten. Additional treatments may be P.T or O.T. Either requires prior authorization.

Reminder to Independent Physical Therapists

Effective August 1, 1999, an independent physical therapist, including a group practice, may bill only for services not provided in a rehabilitation center. An independent physical therapist should refer to Section 2 of the Utah Medicaid Provider Manual for Physical Therapy Services by Independent Physical Therapists NOT in a Rehabilitation Center. For more information on the revision to the current Physical Therapy manual, refer to Bulletin 99 - 76, *Physical Therapy Services by an Independent Physical Therapist NOT Associated with a Rehabilitation Center*.

Independent Occupational Therapists

An independent occupational therapist should refer to Bulletin 99 - 75, *Outpatient Occupational Therapy Services for Adults*, or Section 2 of the Utah Medicaid Provider Manual for Occupational Therapy Services by Independent Occupational Therapists NOT in a Rehabilitation Center.

□